Commonwealth of Virginia
Health Benefits Program

Enrollment Form For Active Employees

Complete health benefits information, including the EmployeeDirect health benefits enrollment system, is available on the Department of Human Resource Management's (DHRM) Web site at **www.dhrm.state.va.us/hbenefit.htm**. If you choose to use this form, return it to your agency Benefits Administrator within the following time periods: 1) by the end of the Open Enrollment period, or 2) within 31 days of employment or an event allowing changes outside Open Enrollment. Please refer questions about this form to your Benefits Administrator.

ENROLLING AS A NEW EMPLOYEE

• *Health Coverage*
As a new employee, you may select a health benefits plan, additional coverage options and type of membership. You must be employed on the effective date of coverage to be eligible for health benefits. To enroll, complete parts A through E. If you choose to waive coverage, complete Parts A, C, and E.

• *Paying Premiums*
Health coverage premiums are deducted automatically from paychecks before taxes.

• *Flexible Reimbursement Accounts (FRAs)*
New employees may enroll in a Dependent Care FRA by completing Part D. However, there is a six-month waiting period for enrollment in a Medical FRA. You must enroll in a Medical FRA in the 31-day period prior to completing your sixth month of employment.

OPEN ENROLLMENT

• *Health Coverage*
Once enrolled, you may change your plan, additional coverage options and type of membership during the annual Open Enrollment period. To make a change during Open Enrollment, see Part B.

• *Flexible Reimbursement Accounts (FRAs)*
There is an Open Enrollment at least once each year for electing FRA participation. For additional details on FRAs, see Part D.

CHANGES OUTSIDE OPEN ENROLLMENT

• *Health Coverage*
You may change membership if you experience an event that permits an election change outside Open Enrollment (qualifying mid-year event). See Part B.

• *Flexible Reimbursement Accounts (FRAs)*
You may change your FRA election if you experience a consistent qualifying mid-year event (see Part B).

ENROLLING IN OTHER THAN ACTIVE COVERAGE

• *Enroll in VSDP – Long Term Disability*
Employees receiving benefits from the Virginia Sickness and Disability Program – LTD (not working) must complete a separate Enrollment Form for Retirees (#T20334) available from your Benefits Administrator. When returning to work from VSDP, see your Benefits Administrator.

• *Enroll as Retiree/Survivor*
There is a separate Enrollment Form (#T20334) for retirees. If you need a copy, please contact the Virginia Retirement System, your Benefits Administrator or visit the Department of Human Resource Management's Web site.

• *Enroll in Extended Coverage*
You may enroll in Extended Coverage by completing a separate form (#T20336) available from your Benefits Administrator or on the Department of Human Resource Management's Web site.

PART A: Employee Information

PLEASE PRINT

Name _____ Social Security Number _____-_____-_____
First Name M.I. Last Name

Address _____
Street City State Zip

Work Phone: (_____) _____ Home Phone: (_____) _____ Sex: ☐ Male ☐ Female Date of Birth _____
MM/DD/YYYY

Work E-mail Address _____ Home E-mail Address _____

CURRENT STATE ENROLLMENT: Are you or any member of your family now covered by one of the State health benefits plans?

☐ Yes ☐ No If yes, give Agency Name _____

PART B: Reason(s) For Submitting Enrollment Form

Contact your Benefits Administrator for benefit effective dates.

(Check all that apply))

☐ **New Employee:** Employment date _____ (includes rehire after 30 days)
- ○ Health Coverage (01)
- ○ Dependent Care FRA (01)
- ○ Medical FRA (after 6-month waiting period) (25)

☐ **Open Enrollment:**
- ○ Health Coverage (56)
- ○ Flexible Reimbursement Account(s) (55)

☐ **Changes Outside Open Enrollment** (indicate event below)
- ○ Health Coverage
- ○ Flexible Reimbursement Account(s)

QUALIFYING MID-YEAR EVENTS (Check one) Date of Event:_____

Change in Your Employment Status

- ☐ Begins leave without pay (49)
- ☐ Begins family medical leave (49)
- ☐ Ends leave without pay (50)
- ☐ Ends family medical leave (50)

Change in Your Marital Status

- ☐ Marriage (07)
- ☐ Divorce (10)
- ☐ Death of spouse (08)

Change in Your Number of Eligible Family Members

- ☐ Birth (15)
- ☐ Covered child is no longer eligible for coverage under your plan (38) (exceeds plan's age limit, marries, becomes self-supporting, etc.)
- ☐ Adoption* (16)
- ☐ Court order to cover a child (71)
- ☐ Permanent custody of a child (72)
- ☐ Death of a covered child (17)
- ☐ DSS order to cover a child (33)

*The Department of Human Resource Management must review all pre-adoptive placements to verify eligibility.

Changes Affecting Your Family Member(s) Employment

- ☐ Spouse or covered child begins employment (28)
- ☐ Spouse or child ends leave without pay (63)
- ☐ Spouse or child ends employment (13)
- ☐ Spouse switched from full-time to part-time employment or vice versa (60)
- ☐ Spouse or child begins leave without pay (64)
- ☐ Eligible child switched from full-time to part-time employment or vice versa (60)

Other Changes Affecting Your Dependent(s)

- ☐ Annual enrollment or change allowed under another employer's plan (62)
- ☐ Day care provider or cost of day care is changing (for Dependent Care FRA only) (61)
- ☐ Gains eligibility for Medicare or Medicaid (66)
- ☐ Loses eligibility for Medicare, Medicaid or another government-sponsored plan (09)

Changes Due To Special Circumstances

- ☐ Permanently moves in or out of plan's service area (05)
- ☐ Special (HIPAA) enrollment due to loss of coverage (70)
- ☐ You or your family member permanently changed residence, affecting eligibility for the State Program (72)
- ☐ A court has required that another party cover your children (67)

PART C: Health Coverage

I. TYPE OF MEMBERSHIP (check one)

☐ Employee Single (S) ☐ Employee Plus One (D) ☐ Family (F) ☐ Waive (W)

II. HEALTH PLAN (check one)

Self-Funded Statewide Plan
Administered By Anthem Blue Cross and Blue Shield

☐ COVA Care (includes basic dental) (CCO)
☐ COVA Care with Out-of-Network (CC1)
☐ COVA Care with Expanded Dental (CC2)
☐ COVA Care with Out-of-Network and Expanded Dental (CC3)
☐ COVA Care with Vision, Hearing and Expanded Dental (CC4)
☐ COVA Care with Out-of-Network, Vision, Hearing and Expanded Dental (CC5)

Regional Fully Insured HMO (Northern Virginia only)

☐ Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. – HMO (KP)

**Note: Kaiser plan members must select a primary care physician.*

Be sure to use a provider or facility that participates in your plan's provider network. Contact the plan or visit its Web site for a list of providers. For services outside Virginia, members of the COVA Care plan should use the Anthem BlueCard PPO network. Consult your Member Handbook for additional information.

III. PAYING PREMIUMS

Please indicate monthly premium amount $ _____.

IV. FAMILY MEMBERS TO BE COVERED (list all)

Relationship Codes: H=husband W=wife S=son D=daughter SS=stepson SD=stepdaughter OF= other female child* OM=other male child*

Name (include last name if different) PLEASE PRINT	Sex Code (M/F)	Birthdate MM/DD/YYYY	Social Security Number	Relationship Code
SPOUSE				
CHILDREN				

If you need more space, list additional children on a separate sheet of paper and attach to this Form.

*Attach explanation. Eligibility must be verified by your Benefits Administrator.

When adding an adult disabled child, see your Benefits Administrator.

PART D: Flexible Reimbursement Accounts (FRAs)

Please indicate which reimbursement account(s) you wish to select by entering your plan year election amount(s) below. Participation in a Medical Reimbursement and/or a Dependent Care Reimbursement Account requires a new FRA election each plan year. If enrolling after the plan year begins, enter the per pay amount to be deducted for the remainder of the plan year. A worksheet is available in the Flexible Benefits Sourcebook and on the DHRM Web site.

MEDICAL REIMBURSEMENT ACCOUNT
Maximum: Contact your Benefits Administrator.
Minimum: $10 per pay period.
☐ Contribution per pay period (in whole dollars): $_____

DEPENDENT CARE REIMBURSEMENT ACCOUNT
Maximum: Contact your Benefits Administrator.
Minimum: $10 per pay period
☐ Contribution per pay period (in whole dollars): $_____

PART E. Certification

AUTHORIZATION: I authorize any medical professional, medical care institution, or any other provider of health care services or supplies to furnish to the plan, Department of Human Resource Management (DHRM) or its agents, information concerning services or supplies provided to me, or persons covered, for the purposes of review, investigation, or payment of a claim. I hereby authorize the plan, DHRM or its agents, to review and/or examine my records as necessary in auditing and administering the State Health Benefits Program. A copy of this authorization is available upon request. I understand that I am entitled to a copy of this authorization, which is available upon request to me or my representative. This authorization is valid for the duration of coverage.

ENROLLEE STATEMENT: Upon enrollment in the State Health Benefits Program, I acknowledge that the cost of coverage I elect shall be payroll deducted on a pre-tax basis. Payment of premiums is based on a monthly amount and partial payments are not allowed. Once enrolled, I understand that changes may only be made at Open Enrollment or with qualifying mid-year events (see Part B) when the changes are consistent with the events. I further understand that notice of cancellation of coverage does not relieve me from my obligation to pay the entire monthly premium for any month of coverage already begun. If the entire monthly premium is not paid, coverage will be terminated and any partial amounts paid will be forfeited. I am aware that the Commonwealth reserves the right to change my coverage to the appropriate plan and membership based on my eligibility and/or plan availability. I understand that non-payment of premium will result in cancellation of coverage.

FLEXIBLE REIMBURSEMENT ACCOUNTS: I certify that I am eligible for the benefit for which I am electing to participate, and hereby authorize the deduction of the elected contributions as indicated above for the duration of the plan year. I understand that this election cannot be revoked, changed, or modified during the plan year unless the revocation and new election are on account of, and consistent with, a qualifying mid-year event, as provided by the plan. I also understand that any amounts remaining in my account(s) not used for qualifying expenses during the plan coverage period for which I am enrolled, will be forfeited in accordance with the current plan provisions and tax laws.

CERTIFICATION: I certify that I have reviewed the information on this enrollment form and that it is complete and accurate to the best of my knowledge. Furthermore, I understand that the State's Health Benefits Program and its business associates have the right to use Protected Health Information in connection with the treatment, payment and operations of these plans as defined by the Health Insurance Portability and Accountability Act.

Print Name _____ Social Security Number _____

SIGN HERE _____ Date _____

Agency Approval/Verification

I certify that I have reviewed this Enrollment Form and that it is complete and accurate to the best of my knowledge.

Agency Name _____ Agency No. _____ Effective Date _____
MM/DD/YYYY

Agency Representative's Signature _____ Date Received _____
MM/DD/YYYY

Print Name and Title_____ Phone No. _____

(Data Entry Note: BES Codes are included with this form in parenthesis.)